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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Mar/19/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: left shoulder (subacromial) ultrasound guided steroid injection

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: M.D., Board Certified Orthopedic Surgery

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of the reviewer that the request for left shoulder (subacromial) ultrasound guided steroid injection is not recommended as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female whose date of injury is xx/xx/xx. The mechanism of injury is described as lifting a heavy object. Progress note dated 01/12/15 indicates that the patient complains of left shoulder pain. The discomfort is currently moderate in intensity and waxes and wanes in severity. The patient has had NSAIDs and has not had any recent treatment. The patient underwent an MRI, but it is not available. The note states that the patient is status post shoulder surgery in 2005 and 2006. Current medications are Bystolic, Cymbalta, Flector patch, hydromorphone, Ketoprofen, Lyrica, Medrol Pak, Neurogel cream, omeprazole, tizanidine, Tribenzor and Vesicare. On physical examination of the left upper extremity there is tenderness to palpation over the lateral aspect of the deltoid. Range of motion is noted to be full. Strength is limited secondary to pain. There is no joint instability on provocative testing. Apprehension test is negative. Speed's test is negative. AC joint compression test is negative. Cross chest adduction test is negative. Neer and Hawkins are positive. The patient underwent steroid injection on this date.

Initial request for left shoulder subacromial ultrasound guided steroid injection was non-certified on 01/29/15 noting that there is no documentation of any diagnostic studies indicating any pathology in the shoulders when the last injection had been performed on left shoulder. The denial was upheld on appeal dated 02/20/15 noting that the records indicate that the patient has had relief with steroid injections in the past but the previous date(s) of injection is unknown. The patient's date of injury is in 2004 and it is unclear what treatment has been provided between the date of injury and the current notes in 2015. There is also mention that an MRI has been ordered; however, the results of those diagnostic studies or any plain radiographs are unknown.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION: The patient sustained injuries in xxxx; however, the earliest record submitted for review is a progress note dated 01/12/15. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient reportedly underwent prior shoulder injections; however, there is no information regarding these procedures submitted for review. There is no indication that the patient has undergone any recent active treatment. The patient reportedly underwent a recent MRI; however, this study is not submitted for review. The Official Disability Guidelines report that steroid injections are generally performed without fluoroscopic or ultrasound guidance. It appears that the patient underwent a shoulder injection on 01/12/15; however, the patient's objective functional response to this injection is not documented to establish efficacy of treatment. As such, it is the opinion of the reviewer that the request for left shoulder (subacromial) ultrasound guided steroid injection is not recommended as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)